Linking OVHA and EDS to your Office

August 2007

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Grievances and Appeals

OVHA is now a managed care organization (MCO) under the federally approved Global Commitment to Health program. As a managed care organization, OVHA must have an internal appeal process for resolving service disagreements between beneficiaries and OVHA or OVHA contractors as required by federal rules. OVHA and the Agency of Human Services (AHS) promulgated rules, effective July 1, 2007, that spell out the new internal OVHA appeal process. These rules apply to all Medicaid-funded services except Choices for Care. Providers that contract with a specific division of AHS should contact that division for more detail about process and expectations. Some of the key points in the rule include the following.

First, you as the provider may ask for a reconsideration of a denial, reduction, or termination of a covered service. This occurred on an informal basis before the rules were enacted. Now the rules inform beneficiaries of this option, especially if there is additional information that might change the decision. Beneficiaries or their representatives may also request reconsiderations on their own.

Second, you as the provider, at the beneficiary's request, may appeal a denial, reduction, or termination of a covered service. Beneficiaries or their representatives can also appeal. An appeal is heard by a qualified person who was not involved in the original decision. You may be asked to attend an appeal meeting by phone or in person, or submit additional clinical evidence for review. At the meeting, you (or your patient or a representative) will be able to present your case for why you think the decision to deny, reduce, or terminate a covered service is wrong. We will try to decide the appeal in 30 days; however, it can take up to 45 days. An extension of 14 days might occur if it is in the beneficiary's best interests (such as to get more information or to reschedule the meeting). The longest it will ever take for a decision to be made is 59 days.

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The beneficiary may ask for a **fair hearing** simultaneously with an appeal.

If you or the beneficiary believe that taking the usual time for an appeal might "seriously jeopardize the beneficiary's life or health or ability to attain, maintain or regain maximum function, either the beneficiary or you on the beneficiary's behalf may ask for an **expedited appeal**. If it is determined that the appeal meets the expedited criteria, you will get a decision within three working days.

Third, a beneficiary may file a grievance or a complaint that may result in a written response from the MCO. The grievance does not involve a denial, reduction or termination of a covered service. Instead, the grievance process is intended to address questions about the quality of care, the manner in which the care was provided, and the like. The MCO will always try to deal with the complaint informally at first, and offer possible avenues for the complaining person to follow, but the MCO will issue a formal, written response, if one is required. If the complaint involves an access issue or quality of care, you may be hearing from an MCO representative to explain the complaint to you and ask for your input in addressing it.

Secure On-Line Services

To submit claims to Vermont Medicaid or to access the secure portion of the Vermont Medicaid web portal you will need an account.

To get an account:

- Go to www.vtmedicaid.com
- Click on Downloads
- Click on HIPAA Tools
- Click on and print EDI Registration and Trading Partner Agreement
- Fill out both documents and mail them to us (both documents require signatures).

EDS will set up your account and mail the account information back to you.

Please be aware that providers will be required to have an account with VTMedicaid to access the Active Provider List when it is moved to the secure sign-in section of Transactions Services in October.

CPT Procedure Code 32999

Since "unlisted" procedure codes are not specific as to the services they represent, prior authorization is required to determine if a specific code already exists for the service being requested, if that service or item is covered, and if it will continue to need prior authorization.

Semi-Electric and Electric Hospital Beds

The OVHA requires the vendor to obtain authorization from the OVHA Clinical Unit before dispensing electric (semi-or total) hospital beds. The last few years have seen HCPCs coding changes involving beds. Please be aware that these beds, like any other defined category, require prior authorization regardless of what procedure code is used and even if a particular code in the category is not up to date in the MMIS files.

HCPCs Procedure Code E0190

Per the Medicaid Rule Manual (previously known as the "Welfare Assistance Manual", WAM), section M840.3, cushions are covered. VTMedicaid has traditionally covered cushions for home use when medically necessary as

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positioning devices and/or to aid in the prevention of skin/tissue breakdown. Reminder: wheelchair cushions have their own HCPCs procedure codes.

Bed wedges, usually foam and often used for gastro esophageal reflux disease (GERD), are not covered because there are appropriate, less expensive alternatives available (M106.4) to raise the head of the bed. Specially designed pillows may be covered as positioning devices but only with prior approval.

Since code E0190 involves multiple items that may and may not be covered, code E0190 requires prior authorization.

CPT Code 55873

Effective immediately, the OVHA will cover cryosurgical ablation of the prostate per Medicare's National Coverage Determination: when the patient has localized, recurrent prostate cancer AND has failed a trial of radiation therapy AND meets one of the following conditions: Stage T2B or below, Gleason score <9, PSA <8 ng/ml.

Behavioral Health Providers

(Web-based Resource to Increase Access to Care)

Practitioner to Practitioner Help (PTOPHELP) is a free, non-commercial web-based resource and referral directory created by Southern Vermont Area Health Education Center (AHEC) in 2002 and designed to link primary care health practitioners with the mental health professional best suited to meet their patients' treatment needs. Over 60% of Medicaid behavioral health providers in Southeast Vermont have enrolled in PTOPHELP. PTOPHELP facilitates timely and appropriate referrals by providing a rich database of professional mental health and substance abuse providers and practice information. Its search tools can pinpoint a practice by insurance plan, discipline, specialty, and location. Joined by the Champlain Valley AHEC in 2006, work is now being directed towards bringing PTOPHELP statewide by encouraging behavioral health providers across the state to enroll in PTOPHELP.

A staggering 50% of patients who could benefit from mental health care do not access the services they need. Factors that may impede this access include poor referral leads, lack of critical information needed to make an appropriate match between patient and therapist, and lag time between acknowledged need for treatment and the right match being made. PTOPHELP addresses many of these gaps by providing detailed referral information quickly and efficiently, at the point of care, or in the privacy of

Contact Us

To request notifications via email:

Vtmedicaidbanners@eds.com

For EDI assistance:

vtedicoordinator@eds.com or 802-879-4450, #3

For EDS Provider Services:

802-879-4450 or

vtprovserv@eds.com

For claims assistance:

In State: 800-925-1706

or: 802-878-7871

or Fax: 802-878-3440

OVHA
312 Hurricane Lane,
Ste. 201
Williston, VT 05495

Phone: 802-879-5900

Fax: 802-879-5919

Hours of operation: Monday through Friday, 7:45 — 4:30, excluding holidays.

the patients' own homes. PTOPHELP works only if practitioners take the time to list themselves. It is simple to do while the potential good you serve with your efforts is great.

Behavioral health providers can enroll by logging on to www.ptophelp.org . A short form is sent to the PTOP data base manager who provides a password. The professional then completes his or her listing (a very important step that drives the matching feature).

If you practice in Champlain, Grand Isle, Addison, Franklin, Orleans, Lamoille, or Essex counties, call 802-257-1474 for more information. If you practice in Windham, Windsor, Rutland, Bennington, Washington, Caledonia, or Orange counties, call 888-758-0676 or 802-885-2126. If you prefer, a paper registration form is available as an alternative to online registration. Please request that the form be sent to you when you call.

Cherie Bergeron
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INTRODUCING CATAMOUNT HEALTH!

The health care reform bill passed by the Vermont legislature during its 2005/2006 session created Catamount Health, a new health insurance plan with premium assistance programs.

Catamount Health is a new health insurance plan that is available starting **October 1, 2007, with access to benefits beginning November 1, 2007,** for uninsured Vermonters. It offers comprehensive, affordable, and quality benefits with low co-payments and premiums, no matter how much you earn. The plan is offered by MVP and Blue Cross Blue Shield Vermont.

Uninsured Vermonters with income less than 300 percent of the federal poverty level (around $2,553 per month or less for one person) may receive premium assistance through Catamount Health or enroll in the Catamount Health Employer-Sponsored Insurance (ESI) plan.

VHAP beneficiaries may be required to enroll in an ESI plan if available and cost-effective to the state.

There will be three new category codes (aid categories) beginning October 1, 2007:

ZA: This code will be used for VHAP beneficiaries enrolled in an ESI plan. These beneficiaries will present both their VHAP card and their ESI card to providers. For ZA beneficiaries, providers will bill in the same way they do now for Medicaid or Dr. Dynasaur beneficiaries with other insurance. The private insurance plan must be billed first. For claims not fully paid by the private plan, providers may bill Medicaid and receive payment up to the Medicaid rate. Only VHAP-covered services will be reimbursed by Medicaid under this wrap-around benefit.

ZB: This code will be used for beneficiaries enrolled in an ESI plan with premium assistance. They, too, will present a VHAP card and an ESI card to providers. However, unlike ZA beneficiaries, ZB beneficiaries will be eligible for wrap-around coverage only for prevention and maintenance services for certain chronic diseases. Later this summer, we will give providers more detailed information on which diagnosis and procedure codes will be included in the wrap-around benefit. If a provider bills a private plan for a service and the private plan does not pay for the service in full, and if the diagnosis and procedure codes are included in the list of covered wrap-around services, the provider may bill Medicaid as the secondary payer and receive payment up to the Medicaid rate.

Providers may not balance bill either ZA or ZB beneficiaries.

ZC: Beneficiaries with a ZC category code are enrolled in a Catamount Health plan with premium assistance. Providers should bill the Catamount Health plan first, and then the beneficiary for any claims not paid by the private insurance plan. OVHA will not reimburse any claims for ZC beneficiaries.

Look for more information later this summer or visit http://hcr.vt.gov!